New Jersey Department of Health and Senior Services
CERTIFICATION OF NEED FOR PATIENT CARE
IN FACILITY OTHER THAN PUBLIC OR PRIVATE GENERAL HOSPITAL

TO BE COMPLETED BY PUBLIC ASSISTANCE AGENCY

Case Name	County Registration No.	Agency Name

Home Address

Health Services Program Case No. *(10 digits)*	Person Number *(2 digits)*	Date of Eligibility

Birthdate (or Age)	Sex	Veteran?	Medicare No. *(if applicable)*
	☐ Male ☐ Female	☐ Yes ☐ No	

Describe Current Living Arrangement

If in an Institution, Name	Admission Date

CERTIFICATION BY PHYSICIAN

This is to certify that the above-named individual requires patient care for the chronically ill because:

1. Diagnosis (Complete): _____
2. Medication and/or Treatment:: _____
3. Other Therapy Contemplated: _____

4. Functional Capacity of the Patient	Inde-pendent	Needs Assistance	Potential for Inde-pendence	Comments
A. Bathing and Personal Hygiene				
B. Dressing				
C. Eating				
D. Toiletry				
E. Communication				
F. Ambulation				
G. Nursing Care				

5. Instructional Needs:
   - A. ☐ Teaching for Independence in Activities of Daily Living
   - B. ☐ Self-Administration of Drugs and Medications
   - C. ☐ Diet and Nutrition
   - D. ☐ Self Care for Special Condition, e.g., Colostomy, etc.
   - E. ☐ Understanding Medical Conditions
   - F. ☐ Prevention Care and Treatment or Complication
   - G. ☐ Counseling, Emotional and Motivation Support

6. Emotional, Behavior or Social Problems (explain): _____

7. Characteristics of Major Disability: ☐ Static of Stable ☐ Progressive ☐ Improving
8. Is patient now receiving any medication or treatment? ☐ Yes ☐ No
   If yes, give details: _____
9. Is surgery or other therapy contemplated? ☐ Yes ☐ No
   If yes, give details: _____
10. Is care in nursing home or public medical institution NOW necessary? ☐ Yes ☐ No
11. If Yes in Question 10, is future discharge contemplated? ☐ Yes ☐ No
12. Could patient be adequately cared for now in a facility providing a lower level of care than that provided by a skilled nursing home? ☐ Yes ☐ No
13. Could this patient be adequately cared for NOW, in:
    -a boarding home? ☐ Yes ☐ No -his own home? ☐ Yes ☐ No
    -other facility (describe)? _____
14. I further certify that, in my opinion, this patient does not require treatment for:
    - ☐ Active Tuberculosis; or
    - ☐ A Mental Disease, Defect or Impairment in an Institution for the Mentally Ill or Mentally Deficient

Name of Physician (Print)	Signature	Date